Initial Approval: July 11, 2018

CRITERIA FOR PRIOR AUTHORIZATION

Diabetic Agents

PROVIDER GROUP: Pharmacy

MANUAL GUIDELINES: All dosage forms of the medications listed in Table 1 below will require prior authorization.

CRITERIA FOR INITIAL APPROVAL FOR ALL PRODUCTS: (must meet all of the following)

- Medication must be prescribed within an FDA-approved age range (outlined in table 1).
- Patient must have a diagnosis of Type 2 Diabetes.
- Patient must have HbA1c above 6.5%
- Patient must have experienced an inadequate response after a trial of a preferred metformin ER agent at a maximum tolerated dose, OR have a documented intolerance or contraindication to metformin ER.
- Prescriber must attest to all medication and/or class-specific safety criteria (outlined in table 1) as it applies to the medication requested.

CRITERIA FOR RENEWAL FOR ALL PRODUCTS: (must meet one of the following)

- Documented improvement of HbA1c from pretreatment levels
- Achievement or maintenance of therapeutic goals (HbA1c $\leq$ 6.5%)

LENGTH OF APPROVAL: 12 months

TABLE 1. MEDICATION AND CLASS-SPECIFIC SAFETY CRITERIA

MEDICATIONS/CLASSES	AGE (YEARS)	MEDICATION/CLASS-SPECIFIC SAFETY CRITERIA
SGLT2 Inhibitor Single Agents and Combinations		
Farxiga® (dapagliflozin)	≥18	- Patient does NOT have a diagnosis of type 1 diabetes - Patient must have a eGFR above: ○ 45 mL/min/1.73m2 ▪ Glyxambi, Invokamet, Invokamet XR, Invokana, Jardiance, Qtern, Synjardy, Syndardy XR ○ 60 mL/min/1.73m2 ▪ Farxiga, Steglatro, Steglujan, Segluromet Xigduo XR - Patient does NOT have any of the following contraindications: ○ End-stage renal disease ○ Currently on dialysis
Glyxambi® (Empagliflozin/linagliptin)	≥18	
Invokamet®, Invokamet XR® (Canagliflozin/metformin)	≥18	
Invokana® (canagliflozin)	≥18	
Jardiance® (empagliflozin)	≥18	
Qtern® (Dapagliflozin/saxagliptin)	≥18	
Segluromet™ (Ertugliflozin/metformin)	≥18	
Steglatro™ (ertugliflozin)	≥18	
Steglujan™ (Ertugliflozin/sitagliptin)	≥18	
Synjardy®, Synjardy XR® (Empagliflozin/metformin)	≥18	
Xigduo XR® (Dapagliflozin/metformin)	≥18	

TABLE 1 (CONT.). MEDICATION AND CLASS-SPECIFIC SAFETY CRITERIA

MEDICATIONS/CLASSES	AGE (YEARS)	MEDICATION/CLASS-SPECIFIC SAFETY CRITERIA
GLP-1 Receptor Agonists		
Adlyxin™ (Lixisenatide)	≥18	- For Bydureon, Bydureon BCise, Byetta, Ozempic, Tanzeum, Trulicity and Victoza ○ Patient does NOT have a history or family history of medullary thyroid carcinoma in the past 2 years ○ Patient does NOT have a history of multiple endocrine neoplasia syndrome type 2 in the past 2 years
Byetta® (Exenatide)	≥18	
Bydureon®, Bydureon® BCise™ (Exenatide ER)	≥18	
Ozempic® (Semaglutide)	≥18	
Tanzeum® (Albiglutide)	≥18	
Trulicity® (Dulaglutide)	≥18	
Victoza® (Liraglutide)	≥18	
Long-Acting Insulin/GLP1 Agonist Combinations		
Soliqua® (Insulin glargine/lixisenatide)	≥18	- Patient is inadequately controlled on: ○ For Soliqua – basal insulin (≤ 60 units daily) or lixisenatide ○ For Xultophy – basal insulin (≤ 50 units daily) or liraglutide - Patient does NOT have any of the following: ○ End stage renal disease (ESRD) ○ History of pancreatitis ○ Diabetic ketoacidosis or type 1 diabetes mellitus ○ Gastroparesis ○ Using prandial (meal-time) insulin ○
Xultophy® (Insulin degludec/liraglutide)	≥18	

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR

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DATE

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PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

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DATE